JEFFREY C. BAILEY, DDS, MS
GREGORY T. ENGEL, DMD, MS

FINANCIAL POLICY

PLEASE READ THOROUGHLY AND INITIAL THE HIGHLIGHTED AREAS!

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your coverage. However, **WE CANNOT GUARANTEE ANY ESTIMATED COVERAGE.** Because the insurance policy is an agreement between you and the insurance company, YOU are directly responsible for all charges. Please know that we will do everything possible to see that you receive the maximum benefits from your policy. Insurance is filed the day after your visit with the information you provide in this paperwork.

If for some reason your insurance company has not paid their portion within 30 days from the filing of the insurance, you are responsible for payment at that time. **IT IS YOUR RESPONSIBILITY TO FOLLOW-UP WITH THE INSURANCE COMPANY REGARDING NONPAYMENT ON YOUR CLAIM.**

PAYMENTS DUE UPON TREATMENT

_____ For no insurance, payment is expected **in full** at time of treatment. We can make financing arrangements with you.

_____ For participating insurances (those insurances in which this office has agreed to accept that company's payment rates)– **ONLY, Cigna Radius/ DPPO Cigna DNSP (NOT** Cigna DPPO Advantage Plan/Core Network**), Delta Dental** (**NOT** Delta Care) The applicable co-payment is to be paid at the time of treatment. **This co-payment is only an estimate; your actual share may vary.**

_____ For **non**participating insurances (all other insurances), a payment of **one-third (1/3) of your total fee is to be paid at the time of treatment.** We will file these insurances as a courtesy to you. You are responsible for the doctor's total fee regardless of what insurance pays.

_____ **Post space, canal obstructions and resin restoration may not be covered by your insurance benefits. You as the insured may become responsible for this procedure if applicable.**

OTHER FEES

_____ **NO SHOWS** –As a courtesy our office will remind you of your treatment appointment in advance. If you do not show at your scheduled time without 24-hour prior notification to our office, you will be assessed an $85 no show fee. Your insurance will not cover this fee.

PARTIAL TREATMENT – If you begin endodontic therapy and then chose on your own recognizance not to complete treatment, you are responsible for the appropriate half-treatment fee, and all subsequent possible oral health complications.

In order to complete treatment and give insurance companies a reasonable amount of time to make payment, there will be no finance charge for the first 60 days after the start of treatment. Any account with a balance after 60 days will be subject to a finance charge of 1.5% per month (18% APR) as well as any expenses that may be incurred collecting past due accounts including 33 1/3% attorney fees, court costs and interest. Any checks returned to us will be charged a $35 returned check fee.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE. I HEREBY AUTHORIZE THE ABOVE NAMED ENDODONTISTS TO FILE DENTAL INSURANCE ON MY BEHALF AND AUTHORIZE PAYMENT DIRECTLY TO HIM FOR THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. **I AM AWARE THAT I AM RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY INSURANCE COMPANY.**

____ / ______________________

PATIENT OR RESPONSIBLE PARTY SIGNATURE **DATE**